Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, February 20, 2025:

- 7:30AM Closed meeting.
- 8:00AM Open Meeting.

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department/Executive Offices) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: kedavis@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, February 20, 2025 • Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Paul Stefanacci CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

1. **CALL TO ORDER –** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **Approval of Quality Council Closed Meeting Agenda – 7:31 AM**
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Scott Baker, Interim Director of Emergency Services; Khoa Tu, MD, ED Medical Director

    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager

4. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:31 AM

3. **CALL TO ORDER –** Mike Olmos, Committee Chair

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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4. **Approval of January Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Scott Baker, Interim Director of Emergency Services; Khoa Tu, MD, ED Medical Director

5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager.*

6. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

1. **CALL TO ORDER -** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF PARTICIPATION –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Approval of January Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1 Environment of Care EOC Quality Report

5. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infection. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

6. **ADJOURN OPEN MEETING -** Mike Olmos, Committee Chair

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will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, January 16, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Marc Mertz, Chief Strategy Officer; Sandy Volchko, Director of Quality and Patient Safety; Dr. Paul Stefanacci, Chief Medical Officer; Evelyn McEntire, Director of Risk Management; Ryan Gates, Chief Population Health Officer; Jag Batth, Chief Operations Officer; Kevin ; Shannon Cauthen, Director of Critical Care; Keri Noeske, Chief Nursing Officer; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Kyndra Licon, Project Manager – Recording.

Mike Olmos called to order at 7:30 am.

Approval of Closed Session Agenda: Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 8:08 am.

Mike Olmos called to order at 8:08 am.

3. **Approval of December Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of December Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: Sandy – the other piece I bring to the Quality Council is related to the Chartis review. We will maintain our 2024 reporting schedule, and the Chartis review will return as a discussion.

    4.1 Annual Review of Quality and Patient Safety Plan
    4.2 Orthopedic Quality Report

5. **Value-Based Purchasing –** a review of completed and planned initiatives to identify and address Value-Based Purchasing. *Erika Pineda, Quality Improvement Manager.*
    - We received our value based purchasing report for Federal Fiscal Year 2025 from California Hospital association, based on their estimates reflecting care/performance from calendar year 2023 with exception of mortality and hip/knee complications. VBP program is an estimated budget-neutral program, hospitals have 2% of payment withheld and can earn it back, and more if their performance meet CMS thresholds. To earn points, you have to achieve or outperform. We are currently 0utperforming in elective THA/TKA complication rate and 2 of our HAI's (CAUTI, MRSA). Our opportunities where we did not earn points are all mortality measures, 3 of our HAI's (C Diff, CLABSI, SSI), all patient experience measures, and MSPB. CHA estimates KH contributed >1.8M and we received back 1.1M – estimating loss of $713K. KH's biggest loss in the VBP program. Several opportunities here. Action plans and development are reporting into the QAPI program through various Kaweah Health Workgroups and Committees listed in this report. Mike questioned that each area has a dedicated team that reviews scores and identifies opportunities for improvement? Sandy added yes, that while some may

be aware of their Value-Based Purchasing (VBP) scores, the focus is on individual performance goals. Stefanacci explained that these programs frequently change, with metrics being introduced, removed, or weighted differently. The goal is to understand how current care delivery is evaluated, assess performance, and determine necessary resources and support. Leapfrog scores play a role in this assessment. Mike inquired whether all categories are weighted equally. Stefanacci clarified that the weightings can change annually and be redistributed. Sandy added that different domains have unique measures, with varying proportions allocated based on program requirements. Stefanacci further explained that Medicare evaluates the population during a specific period, assessing spending per beneficiary. The calculation process is unclear, but it determines whether more was spent on a group and influences potential additional funding. Erika highlighted that Medicare reviews spending three days before and up to 30 days after a hospital submission. In some cases, excess spending is attributed to nursing homes rather than hospitals. However, hospitals are still held accountable for care coordination, creating an opportunity to improve cost management and reduce financial risk.

3. **Rapid Response Team Code Blue Quality Report –** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infection. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
    - The team reported four key metrics to the AHA, with a goal of achieving 85% compliance. These metrics include time to IV administration, the percentage of applicable cases, and the percentage of cases with monitored arrests. Overall, the team was close to full compliance across these metrics, with the exception of capturing airway mangmenet during patient arrests. ICU and stepdown patients with tracheostomies have been identified as an area for improvement. The team is collaborating with Respiratory Therapy to enhance performance in Q4. Internal scorecards are being used to rack progress, and there is an expectation for more consistent success moving forward.
    - There is an opportunity to improve rapid response activation within 24 hours of patient admission. A significant concern remains the number of Code Blue events occurring upon admission from the ED. Discussions with intensivists are ongoing regarding strategies to reduce patient acuity in units 3W and 5T. The team emphasized that step-down staffing and bed allocation remain challenges, and ICU triage strategies are currently under review. Charge nurses and rapid response nurses continue to assist as needed when capacity is exceeded.
    - The Rapid Response Team responds to hospital-wide events, including Code Blue activations, stroke alerts, and trauma cases. Activation criteria are based on significant changes in vital signs, and staff members are encouraged to call for assistance when necessary. The RRT role requires ICU experience, specialized training, and additional certifications. Compensation for RRT nurses is higher than that of bedside nurses but remains below the level of charge nurses. To provide additional support, Assistant Nurse Managers (ANMs) have been trained and will offer increased coverage for night shifts.
    - A multidisciplinary response team is deployed during Code Blue activations, including staff from ICU, ED, pharmacy, respiratory therapy, social work, lab, and patient transport. Each unit is equipped with crash carts and emergency backpacks containing necessary supplies. The team has requested the integration of bedside ultrasound to

enhance airway management during emergencies. Staff members are encouraged to activate a Code Blue or Rapid Response Team without hesitation, and training on this process is provided during orientation. To ensure preparedness, mock Code Blue drills are conducted regularly.

- The team is analyzing locations with high rates of Code Blue activations but low rapid response activations to identify gaps in early intervention. RRT members will begin attending unit staff meetings to reinforce the importance of early intervention strategies. The team is also exploring adjustments to ER admission criteria to improve patient triage. Additionally, efforts are being made to strengthen partnerships between the RRT and bedside nurses to improve patient monitoring and escalation procedures.
- There has been an increase in Code Grey activations, primarily due to long-term hospitalized patients experiencing confusion and requiring additional support. The Workplace Violence Committee and Environmental Operations Committee are reviewing trends and response protocols to improve safety. Specialized security training has been provided to staff, focusing on both physical and non-physical de-escalation techniques. Security personnel receive additional advanced training to handle high-risk situations. A potential presentation by Todd Noeske has been proposed to provide further insight into security and de-escalation strategies.
- The team successfully met all four AHA metrics required for the Gold Award. This achievement was recognized at a recent Board Meeting, highlighted on social media, and celebrated with a team dinner. Moving forward, upcoming projects will focus on enhancing RRT integration with bedside teams to strengthen communication, build rapport, and streamline response processes.

4. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
    - HAI Goals and Peformance; 5 key goals: 3 infection ratios and 2 utilization metrics. One of five is meeting goal – central line utilization. CAUTI goal is 0.02 away from target. Infection ratios are below expected goal which is set at the top 30% performance tier. The team wants to ensure there are meaningful line rounds and making sure there is a good partnership and evaluation as they are key preventative strategies that should be looked at everyday. Daily line utilization rounds to remove unnecessary line. Focus on central line maintenance *(clean dressings, dressing changes, foley bag positioning). Team collaboration is essential for sustained improvements. MRSA prevention key strategies is hand hygiene and decolonization. We are working on electronic tracking for compliance. 100% of patient decolonized when testing positive for MRSA. Our area for improvement is during admission screening and data integration. The team would like to have patient access collect data but it is currently not integrated into the nursing system. IT integration remains a priority challenge due to competing projects. Our hand hygience compliance performance is below target; monthly dashboards are sent ot he leadership. Education materials and flyers are resadily available for staff engagement. EVS team met ATP testing goal and continue to have daily huddles. EVS is currently focusing on bedrails as a key area of improvement. Sepsis managmenet update – 90% bundle compliance in November, second consecutive month above goal. Mortality rate remains above goal of 1.1. Strengthing GME medical record documentation ot meet CMS guidelines. Exploring “Code Sepsis” implementation, similar to Cardiac and Stroke

Alerts. ED leadership engaged in sepsis protocol development. December performance trending positively, ending 2024 on a strong note.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:18am.

Environment of Care
3rd Quarter Report
July 1, 2024 through September 30, 2024
Presented by

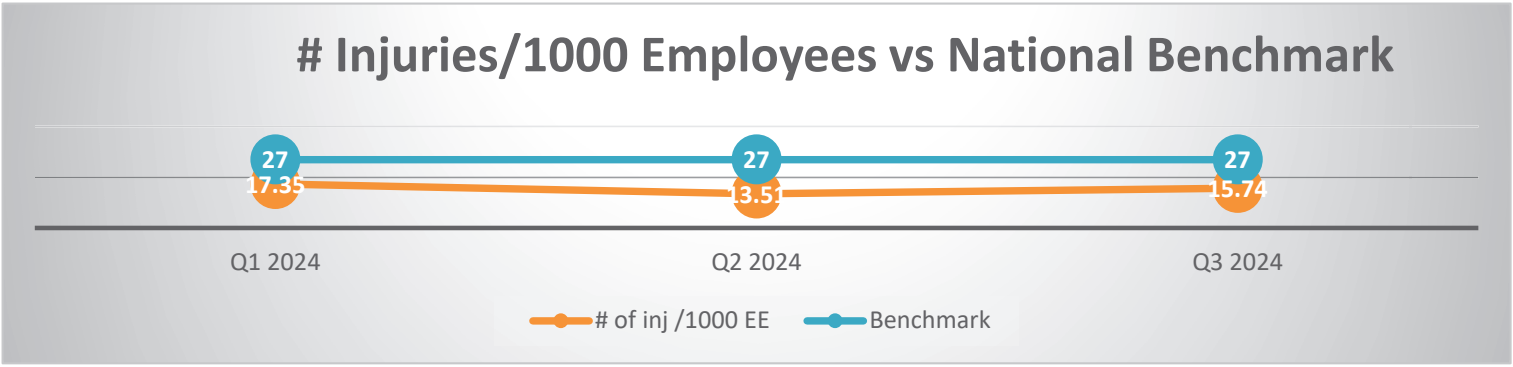
Maribel Aguilar, Safety Officer
maaguila@kaweahhealth.org
559-624-2381

Kaweah Health™

Kaweah Health
Performance Monitoring 3rd Quarter 2024
EOC

Performance Standard: Our goal for 2024 is to maintain a safety record that is better than the national benchmark for workplace injuries and illnesses. To achieve this, we are planning to implement new processes that focus on reducing workplace injuries, keeping track of injury trends by department and type, and improving awareness of potential risks. Our Workers Compensation Program will be providing educational opportunities that align with the most common types of injuries in each department.

Status: Goal met



Evaluation:

- 62 OSHA Recordable Injuries in Q3
- 330 COVID 19 claims, 9 Work Comp
- Provided ergo evaluations Q3
- 15 Sharps Exposure in Q3

Type of Injury	Q1	Q2	Q3	Q4	Total '24	Annualized '24	Totals '23
Total Incidents	170	133	158		461	615	537
COVID 19 +	188	64	330		582	776	991
OSHA Recordable	51	48	62		161	215	323
Lost time cases	38	35	36		109	145	182
Strain/Sprain	49	37	41		127	169	104
Sharps Exp.	16	20	15		51	68	69
# of Employees (EE) end of QTR	4943	4998	5093				

Plan for Improvement:

We have devised a set of processes to ensure safety and prevent accidents at our workplace. These measures include:

- Providing Managers and Directors with quarterly notifications of Work Injury Reports (WIR), which will contain up-to-date year-to-date information.
- Offering education through quick reference guides that can be posted in break rooms, Mandatory Annual Training (MAT) and/or education provided by clinical education or ancillary departments.
- Conducting follow-ups with managers to identify prevention opportunities and/or process changes and policy reviews. The investigation and follow-up may include photos, videos, and interviews of witnesses and managers.
- Increasing Sharps education in General Orientation by Infection Prevention and Manager Orientation by EHS. Demonstrating the correct sharps activation in new hire physicals with all employees handling sharps.
- Utilizing Physical Therapist Aide in Employee Health for Ergo evaluations. Evaluating for proper body mechanics to prevent injury, stretching exercises, and equipment recommendations to ensure safety with our jobs.
- Working with Infection Prevention to track exposures and outbreaks amongst Health Care Workers in 2024.

OSHA recordable injuries and Illnesses are as follows:

- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

Total Incidents include First Aid and Report Only

Infection Prevention Component: **INFECTION PREVENTION HAZARD ROUNDS**

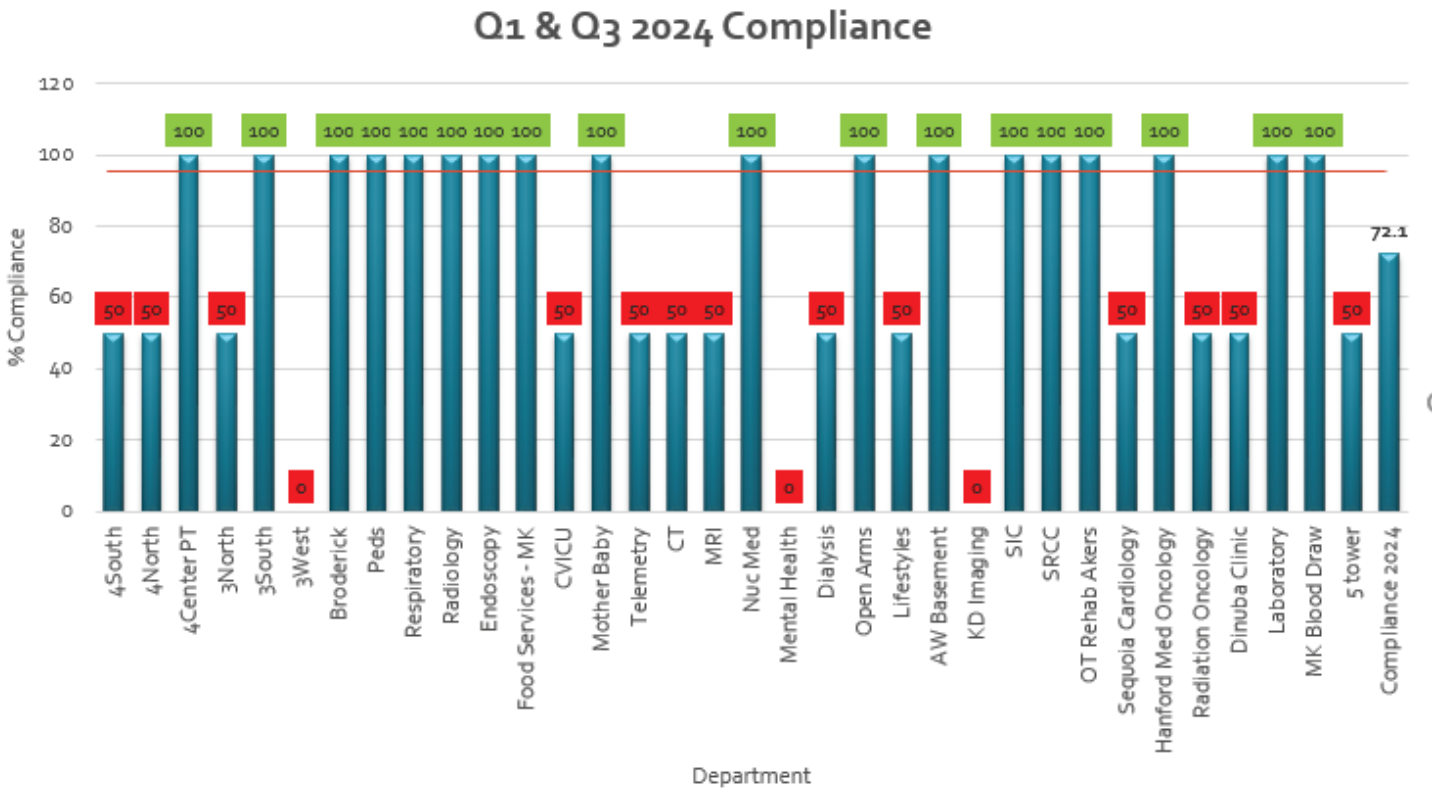
Performance Standard: **Weekly EOC Hazard Rounds 2024 Infection Prevention Goal:**
Will audit for presence of medical supplies, devices and/or medication within 3 feet on either side of sinks present in patient care areas, including outpatient care clinical settings. If present, the audit result is considered a fallout. If not present, the audit result is considered a success.

Goal: 100% compliance (no fallouts).

Status: Goal not met

Evaluation:

Q3 2024 Compliance Rate: **71%. Goal not met.**
33 departments surveyed for Q3 2024. 10 departments were observed out of compliance with medical supplies, devices and/or medication stored within 3 feet on either side of sinks in Q3. The same units were surveyed Q3 and Q1, overall 2024 compliance for these units 72.1% - Q1&Q3 depicted below.



Plan for Improvement:

Methods to mitigate these events from occurring:
1. Eliminate clutter/storage of supplies, devices, medication within 3 feet on either side of a patient care sink.
2. Install an approved hard plastic barrier that prevents water exposure to medical supplies, devices and/or medication that are present within 3 feet on either side of patient care sinks.
3. “Tip-of-the-day” and “One-Page-Wonder” distributed to unit leaders in advance of audits and each time fallout is observed.
4. Infection Prevention and Facilities rounded all inpatient units in Q3. Recommendations for area splashguards developed. Facilities working with unit leaders to install splash guards in recommended areas.

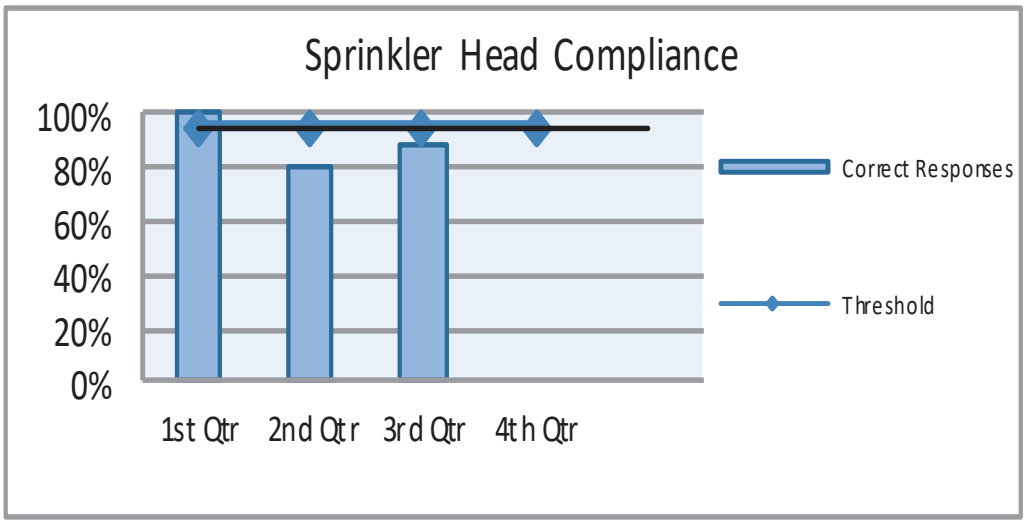
Safety

Third Quarter 2024

Performance Standard: During hazardous surveillance rounding, sprinkler heads will be monitored for damage, corrosion, foreign material, and paint.
Goal 100% compliance
Status: Goal not met for 3rd Quarter 2024

Evaluation:

Eighty four departments were surveyed in the 3rd quarter. Of those departments 10 were found to have foreign material, which resulted in an 88% compliance rate.



Detailed Plan for Improvement:
Environmental Services (EVS) work orders were placed at the time the issue was identified. Findings were sent to EVS leaders at the time of survey. Will continue to work with EVS as issue are identified.

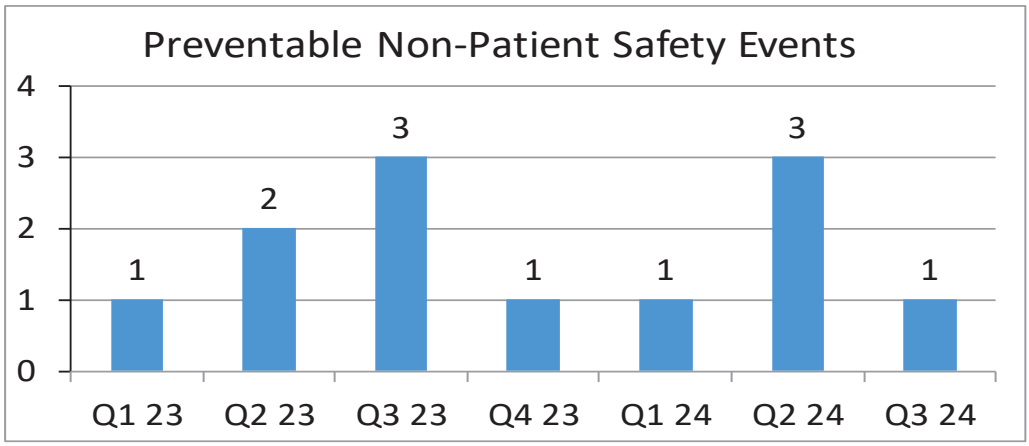
Safety Management (Risk Management)

Third Quarter 2024

Performance Standard: Reports of preventable non-patient safety related events in a KDHCD facility.
Goal: Will decrease by two (2) events or more when compared to 2023
Status: Goal Met

Evaluation:

In 3rd Qtr. 2024, We identified one preventable safety event. Visitor slipped and fell after the floor was mopped by staff. Visitor declined medical treatment and left the facility in stable condition.



Plan for Improvement:

EVS confirmed that at the time of incident wet floor signs were posted and dry mop was used for excess water.

Utilities Management

Third Quarter 2024

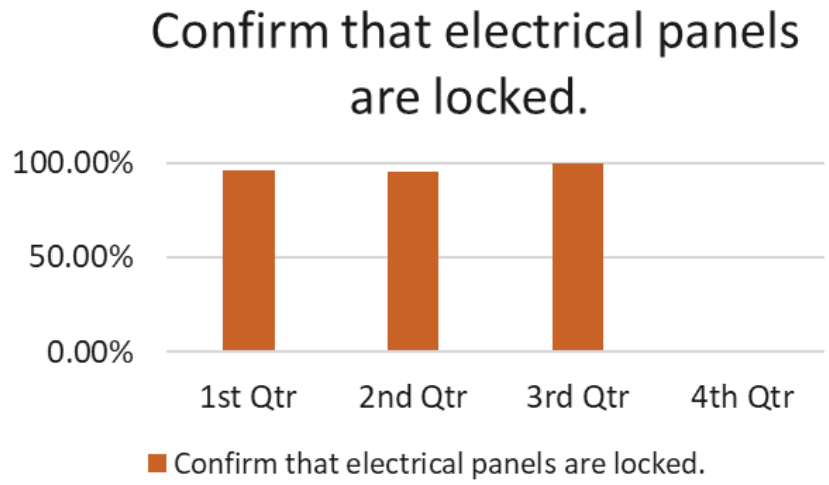
Performance Standard: Inspections will be performed during EOC rounds to confirm that electrical panels are locked.

Goal: 100% Compliance

Status: Goal Met

Evaluation:

45 Departments or buildings were surveyed in the 3rd quarter. No electrical panels were found unlocked, this resulted in 100 % compliance rate.



Detailed Plan for Improvement:
We are searching for a universal surface mount panel lock that is keyless and self latching.

Utilities Management

Third Quarter 2024

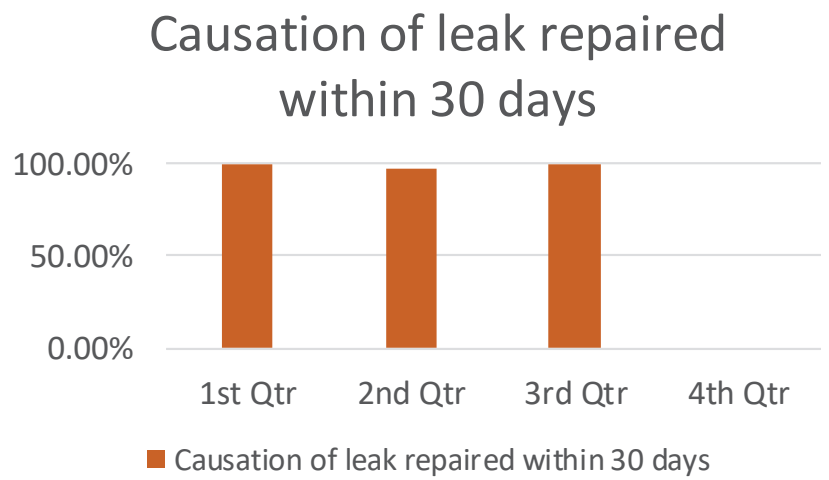
Performance Standard: Inspections will be performed during EOC rounds to identify any ceiling tiles that are damaged/stained. The expectation is staff that work in the area have placed a Facilities Maintenance work order and the Goal is to correction of causation within 30 days of work order being placed.

Goal: 100% Compliance

Status: Goal Met

Evaluation:

45 Departments or buildings were surveyed in the 3rd quarter. Three damages ceiling tiles (not leak relate) were documented. The correction of causation of 3 were repaired within 30 days of work order being placed. This resulted in 100% compliance rate.



Detailed Plan for Improvement:
Damage ceiling tiles (not from a leak) were replaced, causation of damage unknown.

Security Management

Third Quarter 2024

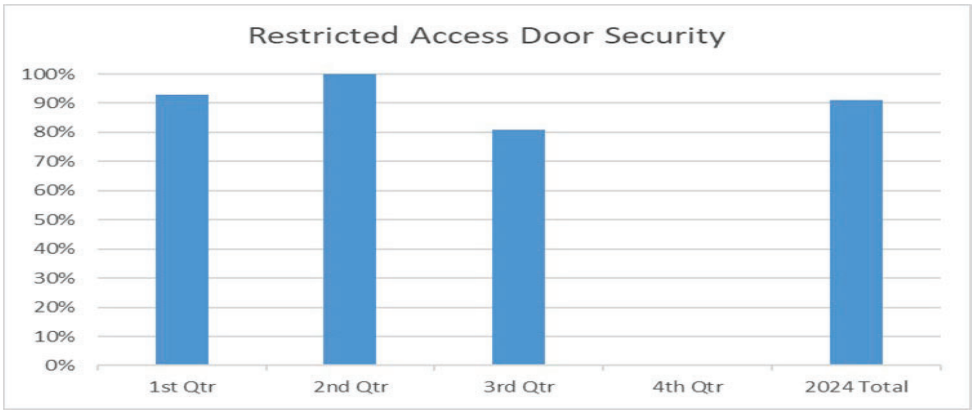
Performance Standard: During hazardous surveillance rounding, units will be evaluated for authorized personnel doors/exit only door accessibility to the public

Goal: 100% Compliance with doors not accessible to the public.

Status: Goal Not Met

Evaluation:

Fifty-two (52) departments were surveyed in the 3rd quarter. In all departments surveyed ten had authorized personnel only doors found accessible to the public, which resulted in an 81% compliance rate.



Plan for Improvement:

Security staff will continue to follow up with Department Leadership of areas with restricted accesses found unsecure to identify causes and partner to identify solutions. Explore addition/ removal of signage to restricted access doors where appropriate.

Environmental Services (EVS) – Environment of Care Rounds (EOC)

Third Quarter 2024

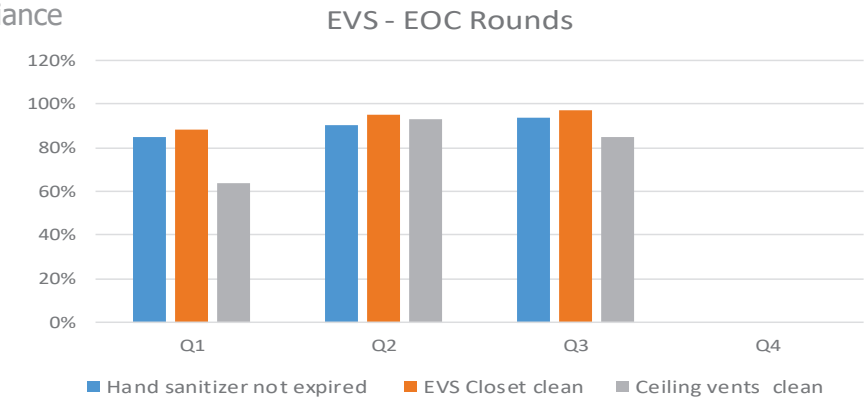
Performance Standard: During EOC rounds, as applicable, the following is evaluated: hand sanitizer not expired; EVS closets are clean; ceiling vents are clean.

Goal: 100% Compliance

Status: Goal Not Met

Evaluation:

1. **Hand Sanitizer not expired: 44/47 = 94% (Not Met)**
2. **EVS Closets clean: 30/31 = 97% (Not Met)**
3. **Ceiling vents clean: 40/47 = 85% (Not Met)**



Detailed Plan for Improvement:

Director re-educated EVS Managers on completing EOC rounding logs in a standardized manner (completed by 5/1/24). Electronic system (RLDatix) has gone live and we're able to record data real-time and also retrieve reports. We have seen an improvement in recording of findings by EVS Leadership as shown by the increase in all denominators over the last 2 quarters. Hand sanitizer and EVS closets clean are above 90% and are showing a positive trend when compared to prior quarters, while ceiling vents clean slightly dropped. We will continue to closely monitor through:

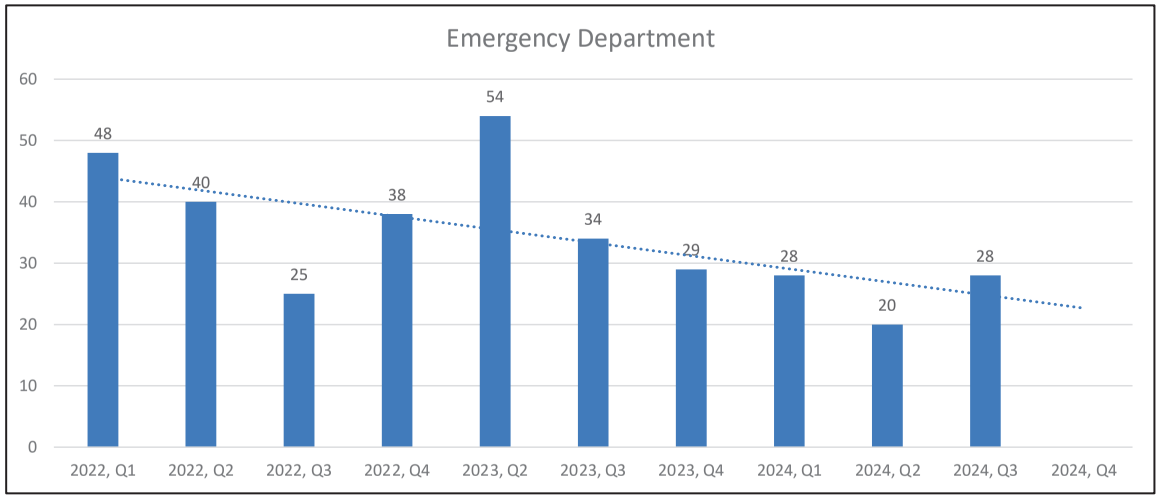
EVS Leadership to proactively monitor areas routinely while completing departmental rounds (ongoing).

EVS Managers to coach staff in non-compliant areas and also recognize compliance as appropriate.

Workplace Violence Report
Safety Department
2024, 3rd Quarter

Kaweah Health
Workplace Violence Report
2022-2024 TD

Year/Qtr	2 North	2 South	2 West-ICU	3 North	3 South	3 Tower-CV ICU	3 West	4 North	4 South	4 Tower	5 Tower	ASC	Acequia Lobby	Cafeteria	CT	ED	Exeter Clinic	Finance Bldg	Hospice	KKC	Labor & Delivery	Lindsay Clinic
2022, Q1	5	1	1	9	3	0	2	3	1	2	1	0	0	0	0	48	0	0	1	1	0	0
2022, Q2	0	4	0	5	2	0	0	0	3	1	0	0	0	0	0	40	0	0	0	0	0	0
2022, Q3	0	1	2	13	2	0	4	5	2	7	6	2	0	0	0	25	0	0	0	0	0	0
2022, Q4	5	3	0	10	9	0	2	2	3	2	3	0	0	0	0	38	0	0	0	0	4	0
Total 2022	**10**	**9**	**3**	**37**	**16**	**0**	**8**	**10**	**9**	**12**	**10**	**2**	**0**	**0**	**0**	**151**	**0**	**0**	**1**	**1**	**4**	**0**
2023, Q1	1	1	0	1	4	2	2	1	1	1	0	0	3	1	1	34	0	0	0	0	0	0
2023, Q2	6	0	0	3	2	2	0	1	2	2	1	0	1	0	0	54	0	0	0	0	0	0
2023, Q3	2	0	1	2	3	0	0	0	4	1	2	0	0	0	0	34	0	0	0	0	0	0
2023, Q4	3	1	1	4	0	1	1	8	7	7	5	0	0	0	0	29	0	0	0	0	1	0
Total 2023	**12**	**2**	**2**	**10**	**9**	**5**	**3**	**10**	**14**	**11**	**8**	**0**	**4**	**1**	**1**	**151**	**0**	**0**	**0**	**0**	**1**	**0**
2024, Q1	1	5	1	0	6	0	1	9	3	3	0	0	0	0	0	28	0	0	0	0	1	0
2024, Q2	↑1	↑1	↑0	↓4	5	0	↑0	↓2	↓10	4	↓1	0	0	↑0	0	↑20	0	0	0	0	0	0
2024, Q3	↑6	↑3	↑3	↓2	5	0	↑5	↓1	↓6	4	↓0	0	0	↑1	0	↑28	0	0	0	0	0	0
2024, Q4																						
Total 2024	**8**	**9**	**4**	**6**	**16**	**0**	**6**	**12**	**19**	**11**	**1**	**0**	**0**	**1**	**0**	**76**	**0**	**0**	**0**	**0**	**1**	**0**



40% increase

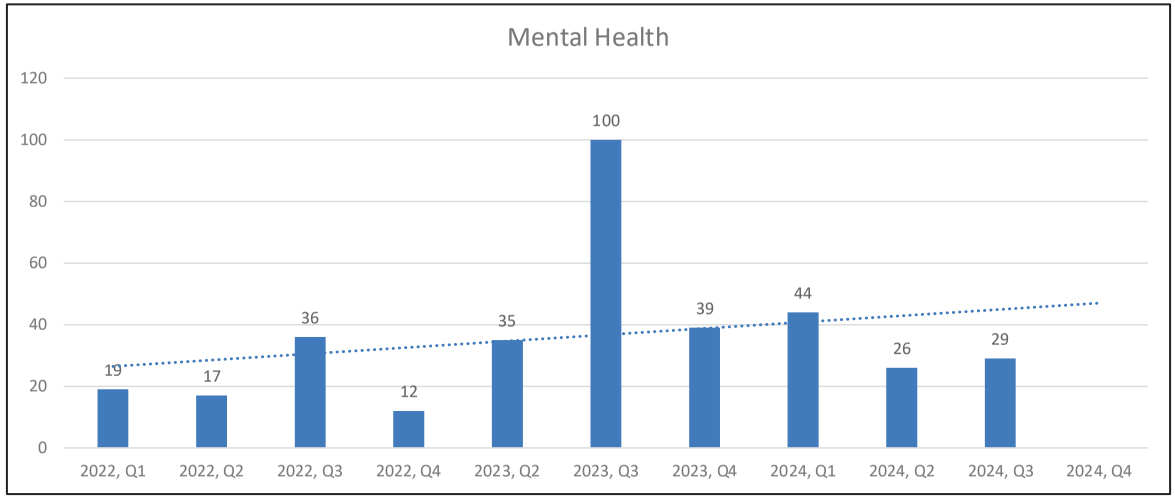
NOTES:
4South Unit staff in process of receiving CPI, Nonviolent Crisis Intervention training. This goal will be completed 12/06/24. Chaplain Services is another group that has been added to the list of department required to receive CPI training.

Kaweah Health
Workplace Violence Report
2022-2024 TD

Year/Qtr	Mental Health	MK Lobby	Mother-baby	MRI	PACU	PBX-Operator	Parking Lot	Peds	Public Area	Rehab Hospital	Respitory	SSB	Specialty Clinic	Sub-Acute, S. Campus	TLC	UCC, S. Court	Visalia Dialysis	Visalia SRCC	West Campus	X-Ray	Total
2022, Q1	19	0	0	0	0	0	0	1	0	0	0	0	0	2	2	1	0	0	0	0	103
2022, Q2	17	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	75
2022, Q3	36	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	108
2022, Q4	12	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	95
Total 2022	**84**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**4**	**2**	**1**	**1**	**1**	**2**	**0**	**381**
2023, Q1	39	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0	96
2023, Q2	35	0	1	2	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	115
2023, Q3	100	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	152
2023, Q4	39	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	109
Total 2023	**213**	**1**	**1**	**2**	**0**	**2**	**5**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**472**
2024, Q1	44	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	103
2024, Q2	26	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	76
2024, Q3	29	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	**95**
2024, Q4																					0
Total 2024	**99**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**274**

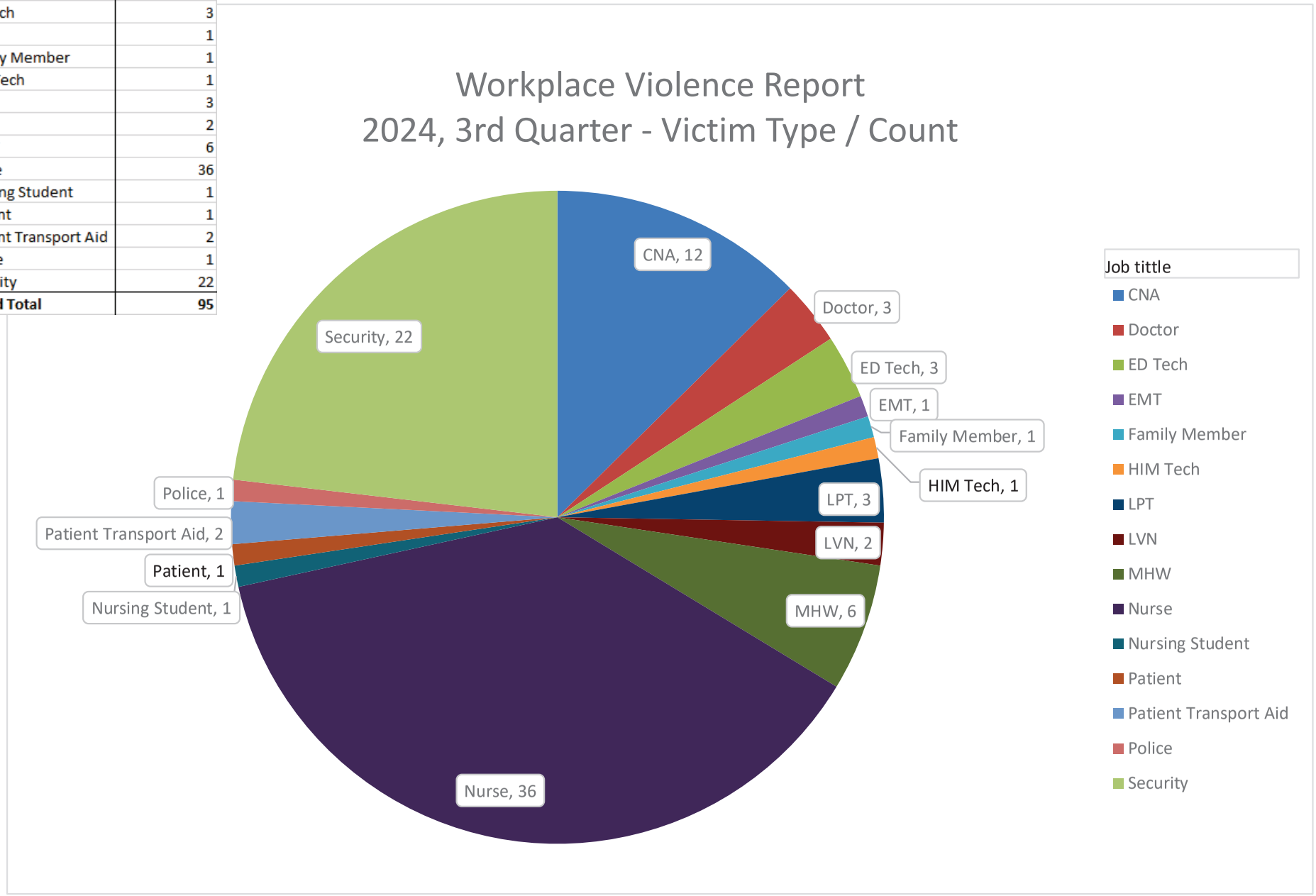
10% increase

25% increase



NOTES:
The Mental Health Clinical Educator is scheduled to attend CPI Instructor class October 21-24 (2024). MH CPI Instructor will support the District's CPI program and will focus on WPV initiatives at Acute Psych Hospital.

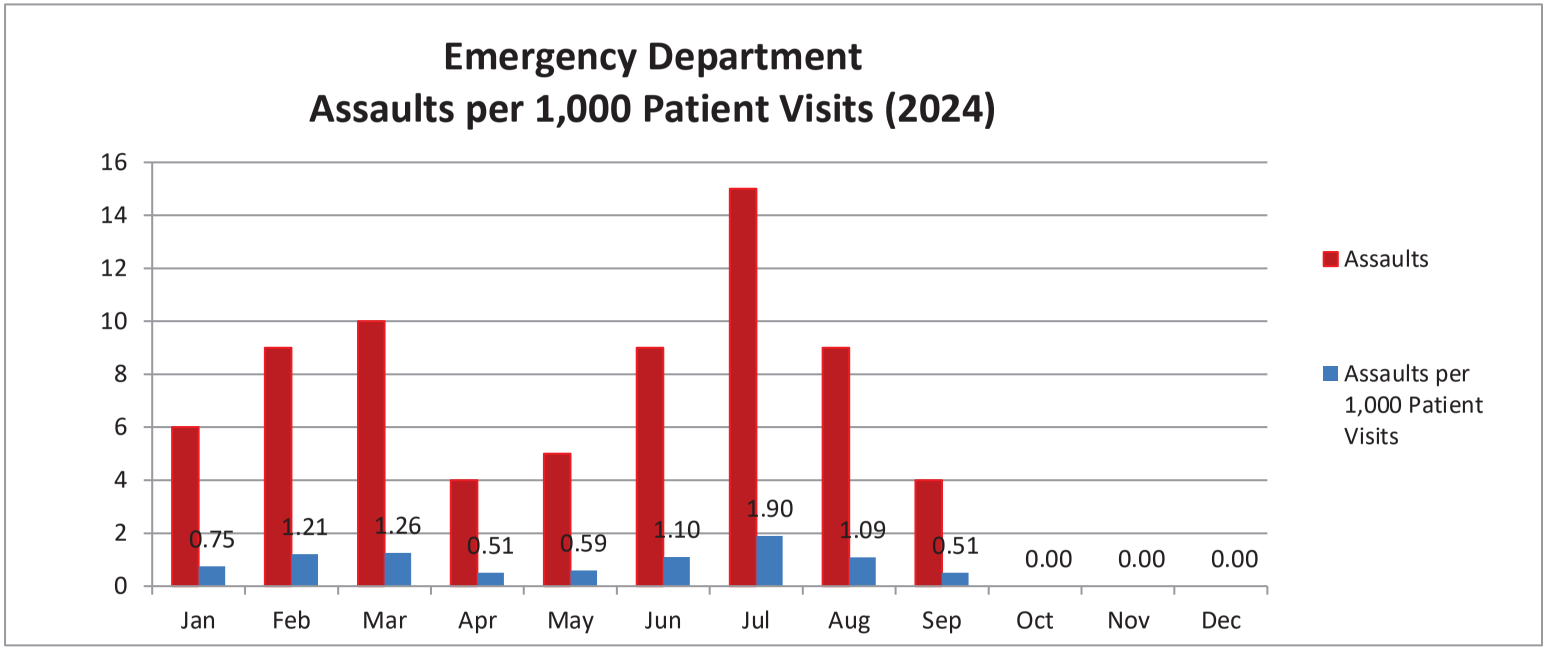
Victim Type	Count
CNA	12
Doctor	3
ED Tech	3
EMT	1
Family Member	1
HIM Tech	1
LPT	3
LVN	2
MHW	6
Nurse	36
Nursing Student	1
Patient	1
Patient Transport Aid	2
Police	1
Security	22
Grand Total	**95**



Kaweah Health
Emergency Department, Assaults per 1,000 Patient Visits
Year 2024, Qtr03

EMERGENCY DEPARTMENT

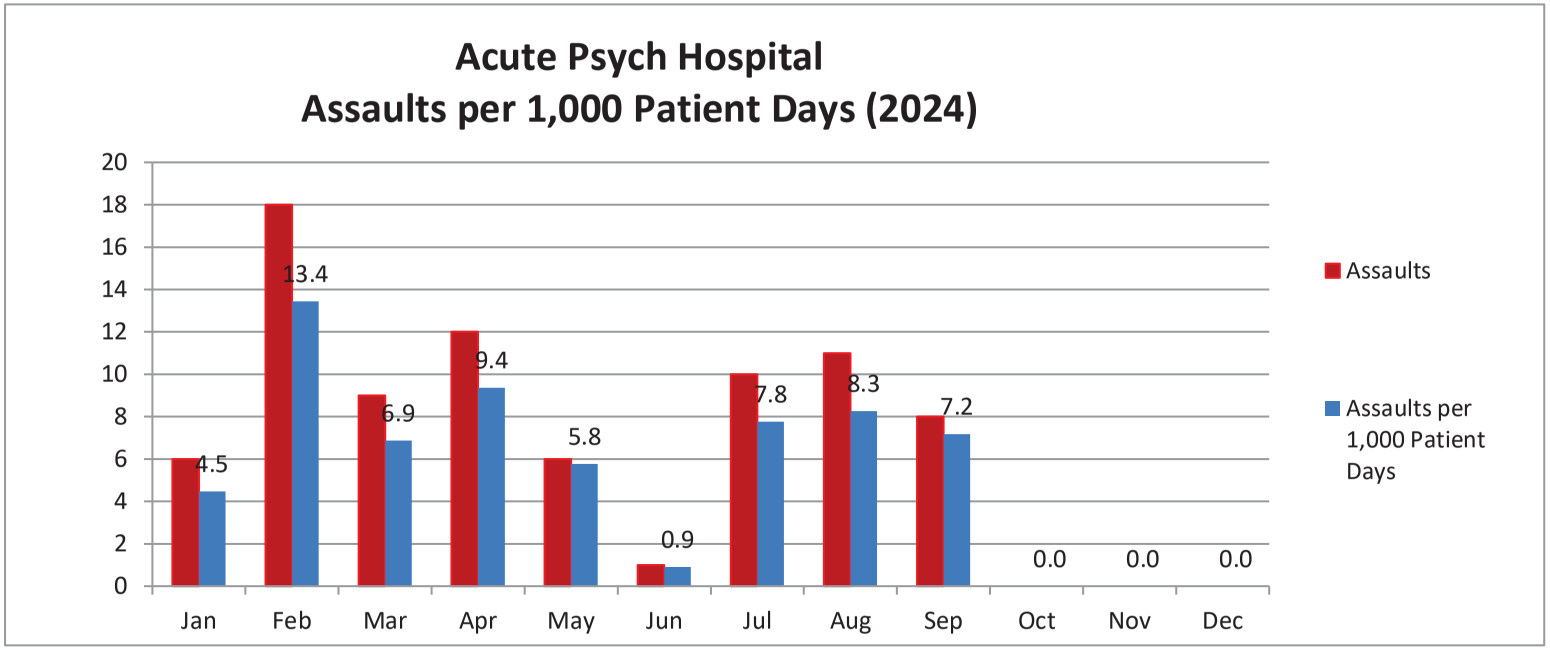
YR 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Days	8,035	7,430	7,921	7,898	8,416	8,161	7,884	8,259	7,875			
Assaults	6	9	10	4	5	9	15	9	4			
Assaults per 1,000 Patient Visits	0.75	1.21	1.26	0.51	0.59	1.10	1.90	1.09	0.51	#DIV/0!	#DIV/0!	#DIV/0!



Kaweah Health
Mental Health Hospital, Assaults per 1,000 Patient Days
Year 2024, Qtr03

MENTAL HEALTH

YR 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Days	1,340	1,339	1,311	1,281	1,039	1,098	1,288	1,331	1,114			
Assaults	6	18	9	12	6	1	10	11	8			
Assaults per 1,000 Patient Days	4.5	13.4	6.9	9.4	5.8	0.9	7.8	8.3	7.2	#DIV/0!	#DIV/0!	#DIV/0!

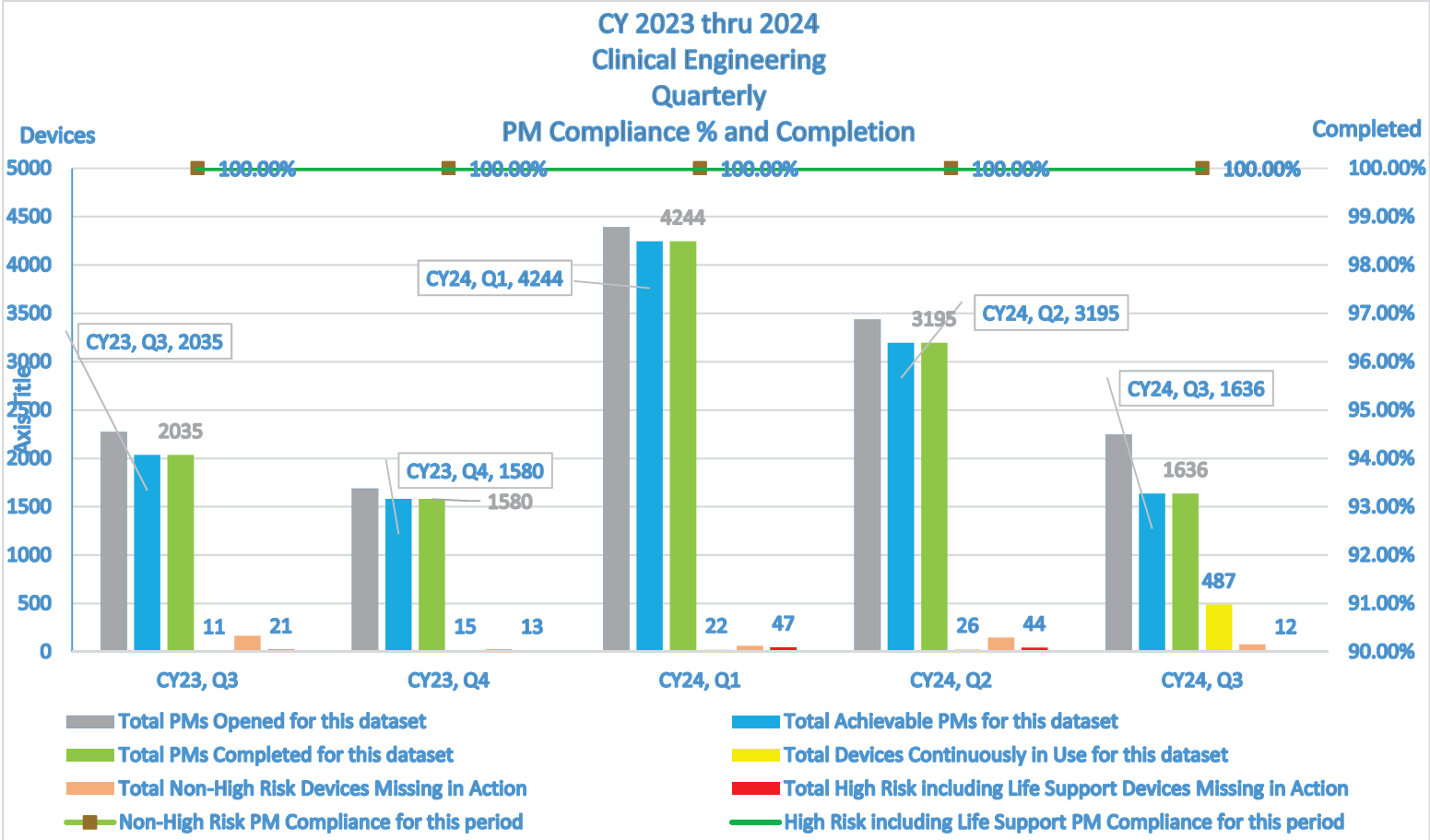


EOC Component: Medical Equipment Preventive Maintenance (PM) Compliance

Performance Standard: Maintain a 100% compliance rate on non-high risk and high risk Medical Equipment
Performance Standard: <2% Total of High Risk Devices to be Missing for Preventative Maintenance per quarter

Evaluation:
For the reporting quarter, CY 2024, Q3 (Jul-Sep), Medical Device count available to receive Preventive Maintenance is 1636 and all of those devices received Preventive Maintenance. All Medical Devices this Quarter received PM or were marked as In Use or Missing in Action (MIA) as defined by policy.

PM Compliance for Non-High Risk Devices is 100% and **meets** the 100% Compliance Goal.
PM Compliance for High Risk Including Life Support Devices is 100% and **meets** the 100% Compliance Goal.
Performance Improvement Goal: Total High Risk Devices MIA count is 12 for the Quarter. Total HRiLS MIA devices as % of total HRiLS inventory is 0.95%. Goal met.



Calander Year 2024	Quarter 3			Q3 Total
Category	**Jul-24**	**Aug-24**	**Sep-24**	**CY24, Q3**
Total PMs Opened for this dataset	1005	220	1020	**2245**
Total Administrative Closures for this dataset	22	5	7	**34**
Total Devices Continuously in Use for this dataset	3	1	483	**487**
Total Non-High Risk Devices Missing in Action	40	0	36	**76**
Total High Risk including Life Support Devices Missing in Action	4	2	6	**12**
Total Achievable PMs for this dataset	936	212	488	**1636**
Total PMs Completed for this dataset	936	212	488	**1636**
Total PMs Not Completed	0	0	0	**0**
Total PM Compliance	100.00%	100.00%	100.00%	**100.00%**
Non-High Risk PM Compliance for this period	100.00%	100.00%	100.00%	**100.00%**
High Risk including Life Support PM Compliance for this period	100.00%	100.00%	100.00%	100.00%

Plan for Improvement: Funds for Passive RFID tags have been approved for FY25. Work will begin in Q4 of CY24 on final vendor selection and defining which High Risk including Life Support medical devices will have these tags applied. Application of the RFID tags is expected to start in CY25 Q1. This system will help reduce the number of HRiLS Medical Devices that were non-locatable by the Clinical Engineering Department and have not been reported by Kaweah Health employees as located with an overdue PM date.

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

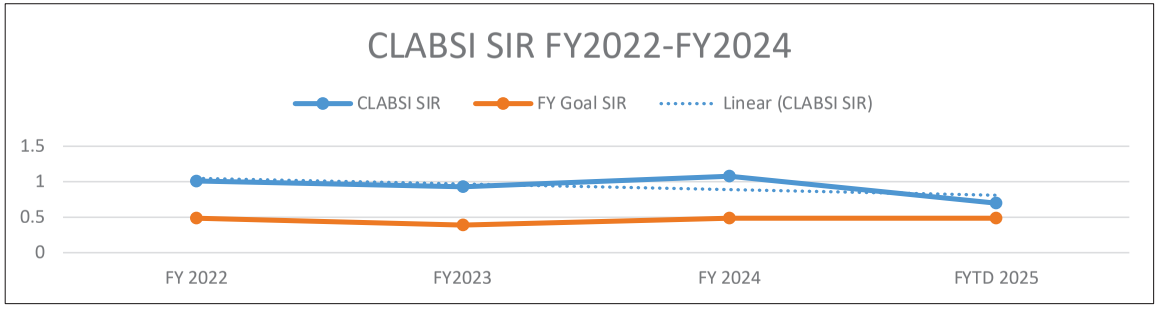
February 2025

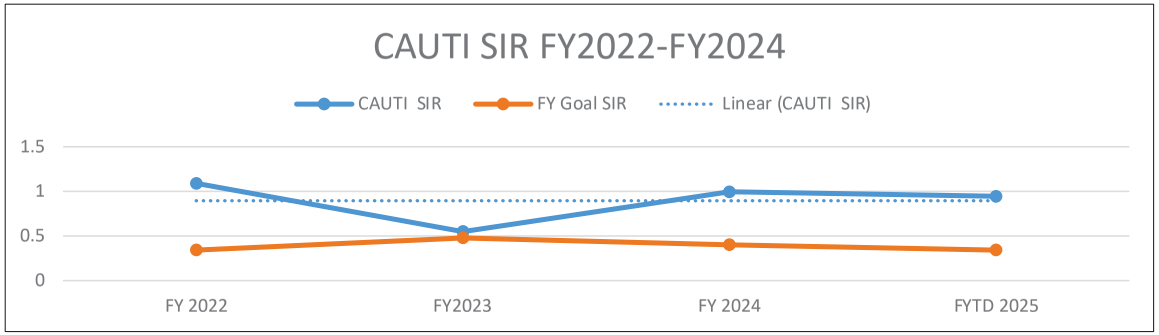
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

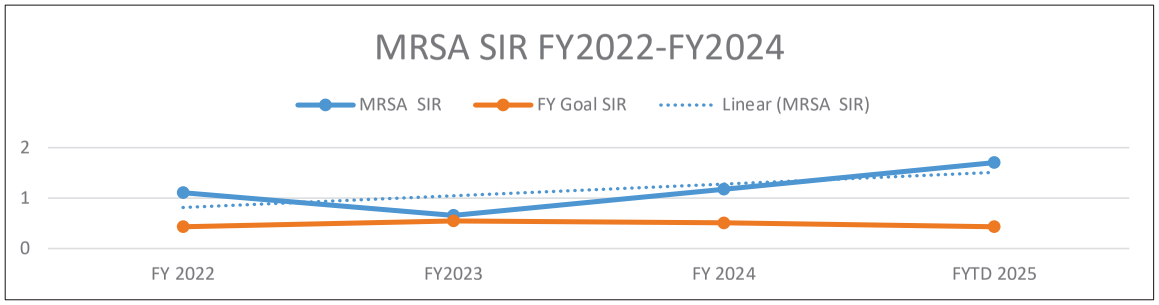
(number of actual infections/number of predicted infections by CMS)

CLABSI - Central Line-Associated Bloodstream Infection; CAUTI - Catheter-Associated Urinary Tract Infection; MRSA - Methicillin-Resistant Staphylococcus Aureus

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

High Level Action Plan

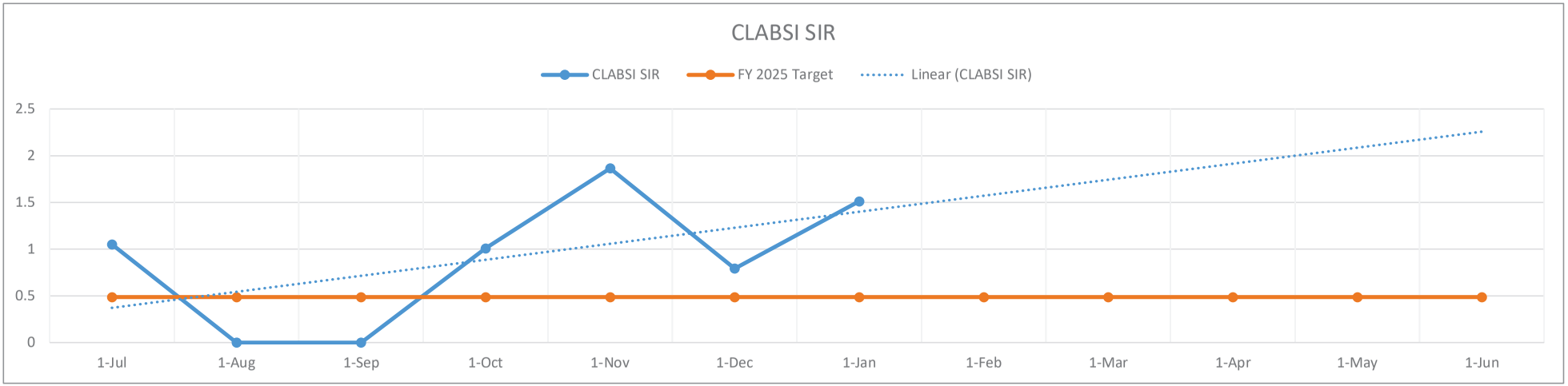
- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

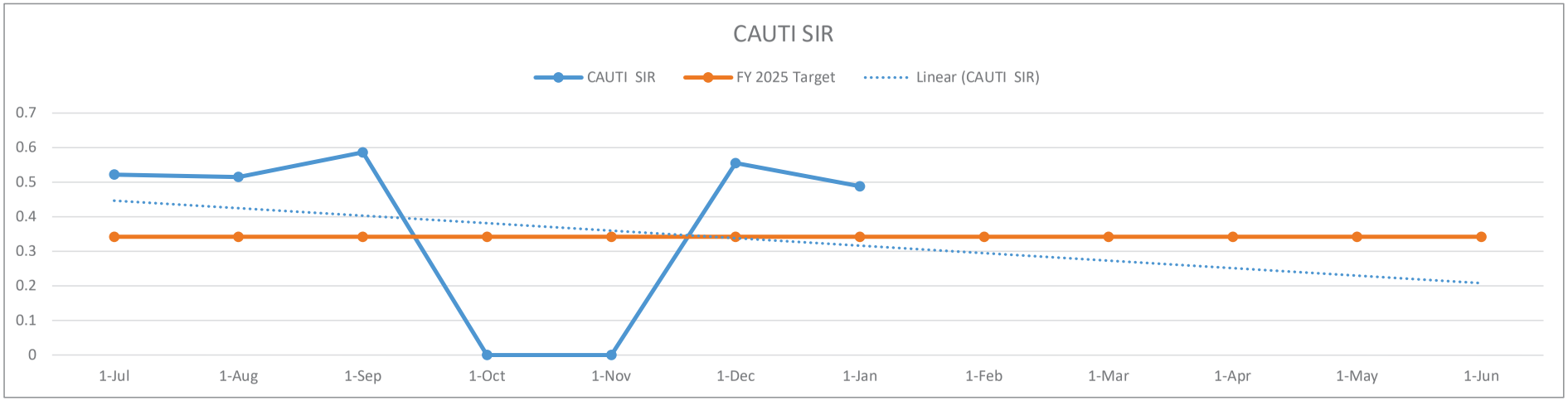
Kaweah Health

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



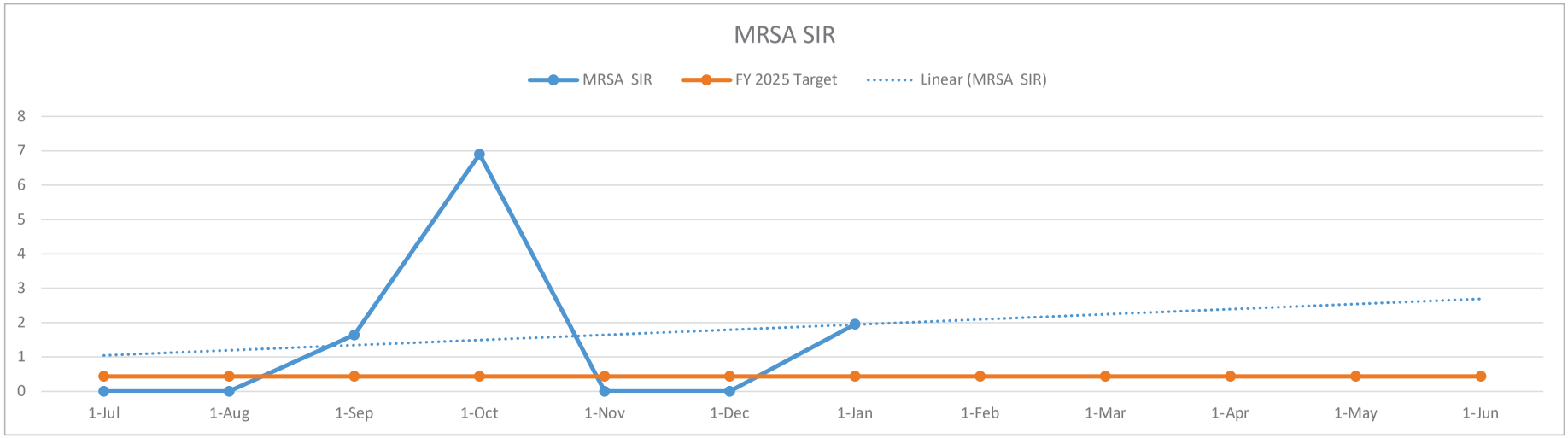
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2						7
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323						7.954
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512						0.88

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0	1	1						5
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54	1.801	2.05						12.532
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488						0.400

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0	0	1						4
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512						4.037
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95						0.99

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July 2024 - Jan 2025 0.63
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - Jan 2025 0.92
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul 2024 - Jan 2025 100% of screen patients nasally decolonized
  - Jul 2024 - Jan 2025 12% of patients admitted from a skilled nursing facility (at risk population) not screened or decolonized (if screen has a positive result)
  - Jul 2024 - Jan 2025 23% of patients re-admitted from another acute care facility within 30 days not screened or decolonized (if screen has a positive result)
  - Goal: 100% of line patients have CHG bathing
  - Will provide update following process implementation, delayed from 10/8 to 11/19 due to Cerner upgrade processes
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul 2024- Jan 2025 54% of staff are active users (January 2025 increased to 60%)
  - HH Compliance rate overall 94% (goal 95%) – decreasing trend noted over 3 quarters
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: >90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)
  - July- Aug 2024 Pass cleanliness effectiveness testing **93%** of the time in high risk areas

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use	3/31/25	Buy in from physician stakeholders
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units	10/8/24 Delayed until 11/19/24	Completed, some staff not yet signed off. Completion reports sent to mangers regularly with options to get CNAs signed off if they work in an area where there are less patients with central lines.
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	3/31/25	Time to establish Cerner workflows for patient access to assist nursing in collecting relevant information from patients
Hand Hygiene compliance dashboard disseminated monthly to leadership (increase awareness and accountability). QI resources disseminated to leadership to use for unit/dept level improvement work	12/2/24 and ongoing	Requests for additional badges/docking stations; periodic inaccurate reports due to the workflow behind electronic removal of termed employees (inhibits leaders ability to hold staff accountability)
Communication with managers of units that are not achieving goal to review their staff level HH compliance reports and follow up with staff. "D.U.D.E, your red" campaign (peer to peer accountability when BioVigil shows need for HH)	3/17/25	None
Effective cleaning – Post staff competency, identify targeted equipment/surfaces for focused QI work	12/31/24	None, completed
Bedrails most frequently failing testing. EVS leadership coaching consistently in staff huddles. Also evaluating different cleaning products with faster kill times that pass testing more often	3/31/25	
Transport staff to help with patient care equipment cleaning	Ongoing	None

Thank you

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Kaweah Health

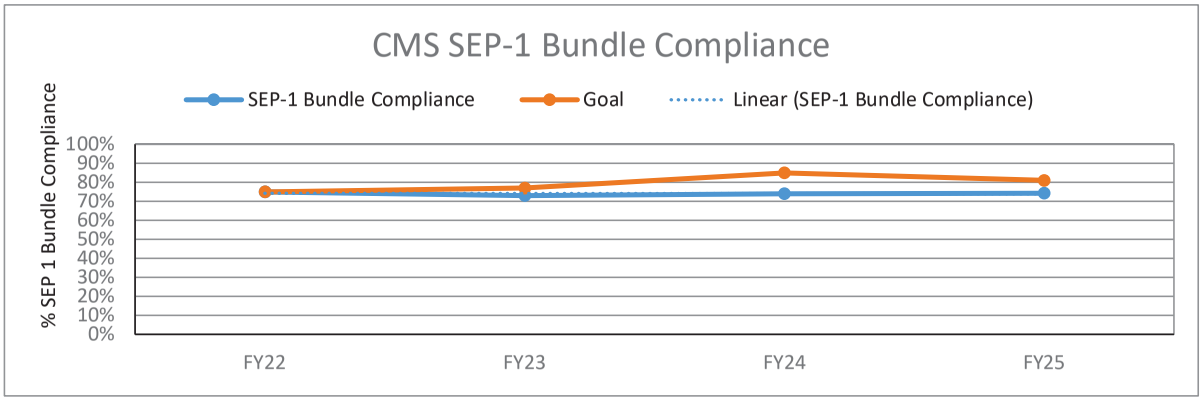
Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

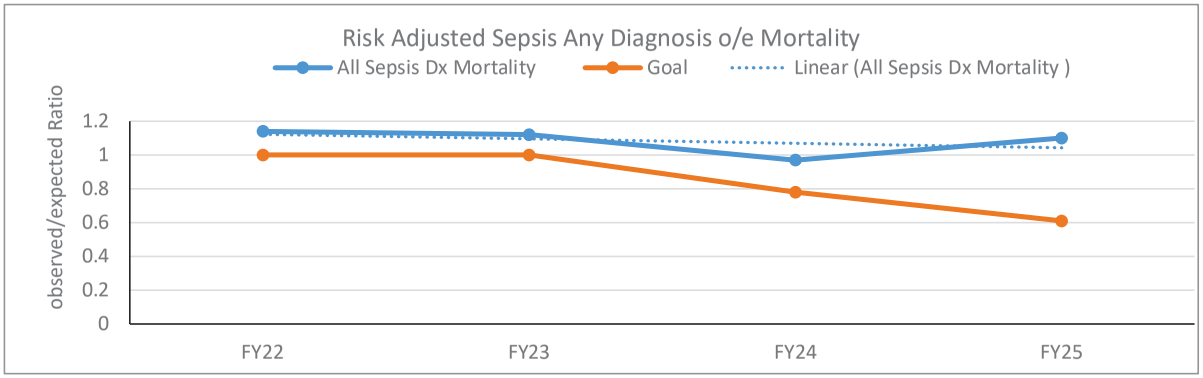
Sepsis CMS SEP-1 & Sepsis Mortality

February 2025

OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)

Historical Baseline





FY25 GOAL

Increase SEP-1 Bundle Compliance ≥ 81%

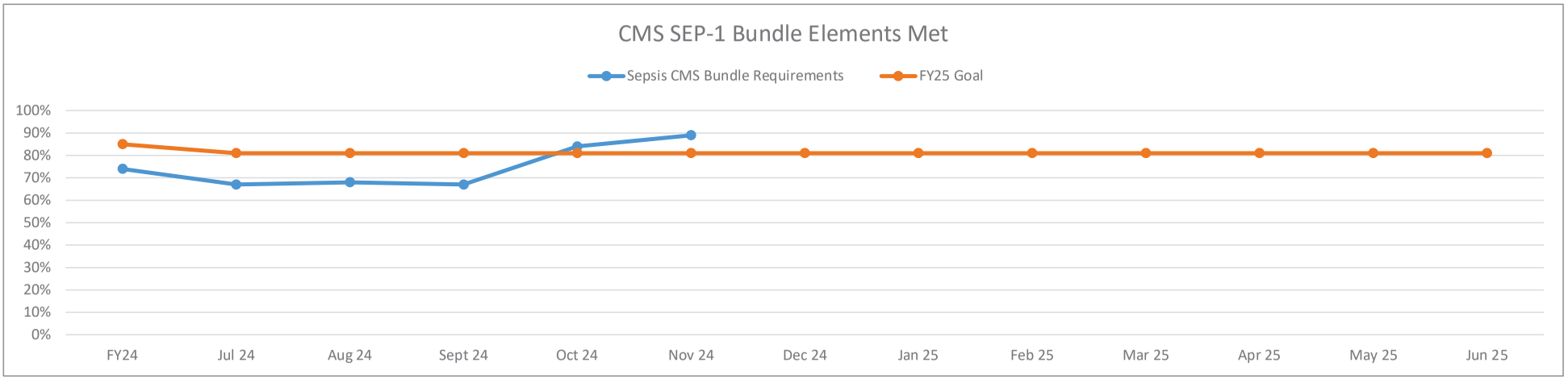
Decrease Sepsis any diagnosis Mortality ≤ 0.61

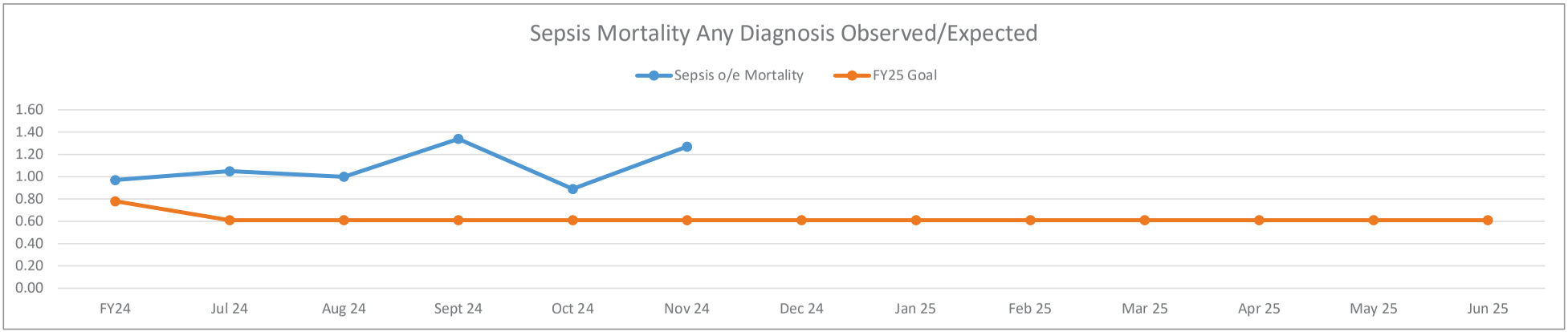
FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)
  - % of Patients provided top 3 most frequently missed Sepsis bundle elements
  - Goal FY 25 95%
    - IV Fluid Resuscitation
    - Antibiotic Administered
    - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)
  - Goal FY 25 = 30%
    - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
    - Pts Met 1- Hr Bundle

OHO FY25 Monthly Update: CMS SEP-1 & Mortality





OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because:

- Differential diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained
- Providers ordering Sepsis bundle elements outside the Sepsis power plan omitting important information required by CMS (i.e., lesser fluids)
  - Providers prefer to order or not order fluid at their discretion due to concerns for fluid overloading patients (afraid to harm pts)
- 1 (one) case BC & **Initial** LA not ordered timely by ED provider, & 1 (one) case BC , **Repeat** LA, & Fluids noted ordered timely by ED provider- Sepsis reassessment not documented by ED provider (multiple elements missed counted as 2 pt. fall outs in total)
- ED Throughput challenges

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 92%
  - Blood Cultures collection 93%

  Goal = 95%
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 29%
  - Pts Met 1- Hr Bundle 26%

  Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing collaboration with Chief ED Residents ✓ Ongoing education during weekly didactic ○ 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer ○ Collaboration with Dr. Stanley for engaging educational material ○ Engage with ACTS team for ongoing Sepsis education to surgical residents ○ Incrementally engage Transitional Year & Psych residents	Ongoing	GME program strict curriculum limited time to devote to ongoing Sepsis education throughout the year
2. Code Sepsis in ED (workgroup in progress)	Discussion to continue once ED Throughput project advanced	ED Throughput challenges, treatment space limitations & staffing challenges No designated blood culture resource Potential for 13-16 code Sepsis in a 24 hour window New ED leadership 1/2025
3. Sepsis multidisciplinary collaboration with SIM (Simulation in Medical Science) Lab Planned for Spring 2025 (possible in situ SIM)	Spring 2025	Potential Inpatient (hospitalist, intensivist) engagement limitations

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
4. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies	First workgroup meeting 12/30/2024	None
5. Improve Severe Sepsis Alert Specificity (EMR optimization) ○ Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert ○ Decrease lookback window (for labs and vital signs) from Cerner 36 hours to **8 hrs.** for more meaningful alerts	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm
6. Sepsis documentation improvement project ○ Trialing reviewing All Sepsis cases for appropriateness of Physician documentation & coding to ensure clinical picture is reflected on the medical record (including Physician linking organism to Sepsis for a more descriptive ICD 10 diagnosis code)	Ongoing	None

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